MO110

- **(M0110) Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?
- ¨ 1 - Early
- ¨ 2 - Later
- ¨ UK - Unknown
- ¨ NA - Not Applicable: No Medicare case mix group to be defined by this assessment.
- **At follow-up go to M0230**

MO110 cont.

- **DEFINITION:** Identifies the placement of the current Medicare payment episode in the patient’s current sequence of adjacent Medicare payment episodes. A “sequence of adjacent Medicare home health payment episodes” is a continuous series of Medicare payment episodes, regardless of whether the same home health agency provided care for the entire series. Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted. “Adjacent” means that there was no gap between Medicare-covered episodes of more than 60 days. Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as *gap* days when counting the sequence of Medicare payment episodes." Early” means the only episode OR the first or second episode in a sequence of adjacent episodes." Later” means the third or later episode in a sequence of adjacent episodes.

MO 110
cont.

- **TIME POINT ITEM(S) COMPLETED:** Start of care Resumption of care Follow-up
- **RESPONSE—SPECIFIC INSTRUCTIONS:** Answer "Early" if the Medicare payment episode is the only episode OR the first or second episode in a current sequence of adjacent Medicare home health payment episodes. Answer "Later" if the Medicare payment episode is the third or higher in the current sequence of adjacent Medicare home health payment episodes. Use the “UK - Unknown” response if the placement of this payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as selecting the “Early” response. Enter “NA” if no Medicare case mix group is to be defined for this episode.

MO 110
cont.

- **ASSESSMENT STRATEGIES:** Consult all available sources of information to code this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of a sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence.

MO 110 cont.

- *When determining if 2 eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode.*
- *Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60.*
- *The first day after the last day of an episode is counted as day 1, and continue counting to, and including, the first day of the next episode.*

MO140

- **DEMOGRAPHICS AND PATIENT HISTORY**
- **(M0175)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**
- ¨ 1 - Hospital
- ¨ 2 - Rehabilitation facility
- ¨ 3 - Skilled nursing facility
- ¨ 4 - Other nursing home
- ¨ 5 - Other (specify) __
- ¨ NA - Patient was not discharged from an inpatient facility **[If NA, go to *M0200*]**

MO 140 cont.

- **DEFINITION:** The groups or populations to which the patient is affiliated, as identified by the patient or caregiver.
- **TIME POINTS ITEM(S) COMPLETED:**SOC (Patient Tracking Sheet)
- **RESPONSE—SPECIFIC INSTRUCTIONS:** Response 1: American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Response 2: Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Response 3: Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American." Response 4: Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino." Response 5: Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Response 6: White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **ASSESSMENT STRATEGIES:** Interview patient/caregiver. The patient may self-identify with more than one group; mark all that are noted.

MO150

- **(M0150)** **Current Payment Sources for Home Care: (Mark all that apply.)**
- ¨ 0 - None; no charge for current services
- ¨ 1 - Medicare (traditional fee-for-service)
- ¨ 2 - Medicare (HMO/managed care)
- ¨ 3 - Medicaid (traditional fee-for-service)
- ¨ 4 - Medicaid (HMO/managed care)
- ¨ 5 - Workers' compensation
- ¨ 6 - Title programs (e.g., Title III, V, or XX)
- ¨ 7 - Other government (e.g., CHAMPUS, VA, etc.)
- ¨ 8 - Private insurance
- ¨ 9 - Private HMO/managed care
- ¨ 10 - Self-pay
- ¨ 11 - Other (specify) ___
- ¨ UK - Unknown

MO150

- The purpose of this data item is to identify the current payer's) that your agency will bill for services provided by your agency during this home care episode. Note that the text of M0150 asks for the "current payment source**s**" (emphasis added) and contains the instruction, "Mark all that Apply."
- The item is NOT restricted to the primary payer source.
- When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer.

ASSESSMENT STRATEGIES:

- Referral source may provide information regarding coverage.
- This can be verified with patient/caregiver
- Ask patient/caregiver to provide copy of card(s) for any insurance or Medicare coverage.
- This card will provide the patient ID number as well as current status of coverage.
- The agency billing office may also have this information
- Determine if the patient has any out-of-pocket expenses for services received in the home

MO 150
cont.

- *Limited to payers your agency will bill for services provided during the episodes.*
- *The item is NOT restricted to the primary payer source.*
- *Example: A Medicare patient is involved in a car accident and someone's car insurance is paying for his/her home care, Medicare is the secondary payer and the response to MO 150 should include either response 1 or 2 as appropriate for that patient.*

DEMOGRAPHICS AND PATIENT HISTORY

- **(M0175)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**
- ¨ 1 - Hospital
- ¨ 2 - Rehabilitation facility
- ¨ 3 - Skilled nursing facility
- ¨ 4 - Other nursing home
- ¨ 5 - Other (specify) __
- ¨ NA - Patient was not discharged from an inpatient facility **[If NA, go to *M0200*]**

MO175 cont,

- **DEFINITION:**
- Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care.
- **TIME POINTS ITEM(S) COMPLETED:**
- Start of care
- Resumption of care

Mo180

- **(M0180)** **Inpatient Discharge Date** (most recent):
- __ __ /__ __ / __ __ __ __
- month day year
- ¨ UK - Unknown
- **DEFINITION:**
- Identifies the date of the most recent discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)
- **TIME POINTS ITEM(S) COMPLETED:**
- Start of care Resumption of care

MO 180 cont.

- **RESPONSE—SPECIFIC INSTRUCTIONS: Even** though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility. If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- **ASSESSMENT STRATEGIES: Obtain** information from patient, caregiver, or referring physician. For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

MO 190

- ¨ UK - Unknown
- **(M0190)** List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no surgical, E-codes, or V-codes):
- Inpatient Facility DiagnosisICD-9-CM
- a. _____(__ __ __ • __ __)
- b. _____(__ __ __ • __ __)
- **DEFINITION:**
- **Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)**
- **TIME POINTS ITEM(S) COMPLETED:**
- **Start of care**
- **Resumption of care**

MO190 cont

- **RESPONSE—SPECIFIC INSTRUCTIONS:**
- Include only those diagnoses that required treatment during the inpatient stay. If a diagnosis was not treated during an inpatient admission, do not list it. (Example: The patient has a long-standing diagnosis of "osteoarthritis," but was hospitalized for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.) This is the diagnosis for which the patient received treatment, not necessarily the hospital admitting diagnosis (though it can be the same). No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure. No V-codes or E-codes. List the underlying diagnosis.
- **ASSESSMENT STRATEGIES: Obtain** information from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

MO200

- **(M0200) Medical or Treatment Regimen Change Within Past 14 Days:** Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?
- ¨ 0 - No **[If No, go to *M0220*; if No at Discharge, go to *M0250*]**
- ¨ 1 - Yes
- **DEFINITION: Identifies** if any change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an existing diagnosis within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.)
- **TIME POINTS ITEM(S) COMPLETED: Start** of care Resumption of care Discharge from agency – not to an inpatient facility
- **RESPONSE—SPECIFIC INSTRUCTIONS: If** "No" is selected at discharge, the clinician should be directed to skip to M0250 (Therapies).
- **ASSESSMENT STRATEGIES: Obtain** information from patient, caregiver, or referring physician. Note that the item addresses any change in the medical or treatment regimen within the past 14 days. A physician appointment alone or a referral for home health services does NOT qualify as a medical or treatment regimen change. A treatment regimen change that occurs on the day of the assessment does fall within the 14-day period.

MO 200 cont.

- *Identify whether any change has occurred in the patient's medical or treatment regimen in the past 14 days.*
- *Is there a new diagnosis or an exacerbation of an old diagnosis that necessitates a change in treatment regimen?*
- *For example, has there been a medication dosage change?*
- *Are therapy services newly ordered as a treatment regimen change?*
- Has a regimen change occurred in response to a change in patient health status?
- Time specific item.

MO210

- **(M0210)** List the patient's **Medical Diagnoses** and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes)::
- Changed Medical Regimen DiagnosisICD-9-CM
- a. _____(__ __ __ • __ __)
- b. _____(__ __ __ • __ __)
- c. _____(__ __ __ • __ __)
- d. _____(__ __ __ • __ __)
- **DEFINITION: Identifies** the diagnosis(es) that have caused an addition or change to the patient's treatment regimen, health care services received, or medications within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the discharge visit].)
- **TIME POINTS ITEM(S) COMPLETED: Start** of care Resumption of care Discharge from agency – not to an inpatient facility

MO 210 cont

- **RESPONSE—SPECIFIC INSTRUCTIONS: Can** be a new diagnosis or an exacerbation to an existing condition. No surgical codes - list the underlying diagnosis. No V-codes or E-codes - list the appropriate diagnosis. Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.
- **ASSESSMENT STRATEGIES:** Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

MO220

- **(M0220) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days**: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**
- ¨ 1 - Urinary incontinence
- ¨ 2 - Indwelling/suprapubic catheter
- ¨ 3 - Intractable pain
- ¨ 4 - Impaired decision-making
- ¨ 5 - Disruptive or socially inappropriate behavior
- ¨ 6 - Memory loss to the extent that supervision required
- ¨ 7 - None of the above
- ¨ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- ¨ UK - Unknown
- **DEFINITION:** Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.)

MO220 cont

- **TIME POINTS ITEM(S) COMPLETED: Start** of care Resumption of care Discharge from agency – not to an inpatient facility
- **RESPONSE—SPECIFIC INSTRUCTIONS: Mark** "NA" if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be correct. All references to inpatient facility stay or facility discharge are omitted at the discharge assessment (from the home health agency).
- **ASSESSMENT STRATEGIES: Interview** patient/caregiver to obtain past health history. Additional information may be obtained from the physician. Determine any conditions existing before the inpatient facility stay or before the change in medical or treatment regimen.

MO 230/240/246

- The focus of this coding session will be related only to OASIS data collection guidelines and requirements.
- Additional resources offered in Attachment D to Chapter 8 of OASIS implementation manual

Primary Diagnosis

- The principal diagnosis is the diagnosis most related to the *current plan of care.*
- It may or may not be related to the patient's most recent hospital stay, *but must relate to the services you render.*
- If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition *and* requires the most skilled services.

Secondary Diagnosis

- Enter all pertinent diagnoses relevant to the care rendered
- Include all conditions that coexisted at the time the plan of care was established or which developed subsequently, or affect the treatment or care
- Manifestation codes are always secondary.

Secondary Diagnosis cont.

- Should include not only conditions actively addressed in the plan of care but also any co morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself
- These co morbidities should usually be coded as they have the potential to become exacerbated or they may impact the agency's plan of care

"…Even If Not The Focus Of Care…"

- Diabetes
- Hypertension
- Coronary Artery Disease
- Peripheral Vascular Disease
- Chronic Neurological Diseases – Parkinson's, MS, ALS
- Blindness
- Status Post-Amputation
- History of Neoplasm

Selection & Sequencing

- List the diagnoses in order of their severity and/or impact on the patient
- The diagnoses' severity ratings on the OASIS will *most likely* be in descending order:
  - 4 - Symptoms poorly controlled, history of rehospitalizations
  - 3 - Symptoms poorly controlled; needs frequent adjustment in treatment and dose monitoring
  - 2 - Symptoms controlled with difficulty, affecting daily functioning; needs ongoing monitoring
  - 1 - Symptoms well controlled
  - 0 - Asymptomatic, no treatment

When Should Code Selection & Sequencing Occur?

- ***After*** the home health assessment has been performed, and
- ***After*** the plan of care has been established
  - In a perfect world, this would include all disciplines' assessments and plans of care as this will impact sequencing

Mandatory Multiple Coding

- This is a mandatory sequencing rule which requires two codes to be reported in a specific order. Both codes must be assigned to fully describe the condition. These codes describe a single condition that affects (or has the potential to affect) multiple body parts
- These two codes must be reported one (etiology) right after the other (manifestation) on the OASIS

Recognizing Mandatory Multiple Coding

This situation can be recognized in the coding manual by the following conventions:

- The **Alpha Index** will list two codes with the underlying condition (etiology) reported first followed by the specific problem (manifestation) in slanted brackets with italicized numbers within
- The **Tabular List** will include the instruction to "use an additional code to identify manifestation" when verifying the etiology code and will instruct you to "code first causal condition or underlying disease" when verifying the manifestation code

Etiology & Manifestation Example

- **Diabetic Toe Ulcer**
- The Alpha Index will report this condition as 250.8x *[707.15]*
- When verifying these codes in the Tabular List there will be an instruction at the etiology, 250.8x, “Diabetes with other specified manifestations,” which tells us to “use an additional code to identify manifestation”
- When verifying the manifestation, 707.15, “Ulcer of the toes,” there will be an instruction to “code first causal condition or underlying disease”

Attachment D

- **In order to facilitate accurate payment under HHPPS, in some cases, guidance from Attachment D for *MO245/246* will supersede Official ICD-9 coding guidance.**

Case Mix Diagnosis

- These diagnoses contribute to the patient's case mix index and therefore are *only intended to facilitate PPS payment operations or proper payment calculation for any other payer source that requires a HHRG for episodic reimbursement*
- May receive points in M0230 and/or any blank (b-f) of M0240 or in M0246 in Columns 3, or Columns 3 and 4 when V-codes are replacing diagnoses which require mandatory multiple coding per the ICD-9-CM

MO 230/240/246

M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses:

List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2)

Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis)

- V-codes (for M0230 or M0240) or E-codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.
- If a V-code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group

MO 230/240/246 cont.

Code each row as follows:
(Column 1): Enter the description of the diagnosis
(Column 2): Enter the ICD-9-CM code for the diagnosis described in Column 1;

- Rate the severity of the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of rehospitalizations

MO 230/240/246

- (Column 3) (OPTIONAL) If a V-code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row

MO 230/240/246 cont.

(Column 4) (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row

REFERENCES

- OASIS Implementation Manual 01/08
- Attachment D to OASIS Implementation Manual 01/08
- CMS Q&As 08/07
  - https://www.qtso.com/hhadownload.html
- AHIMA ICD-9 Coding Manual
  - www.ahima.org